A 61-year-old male was admitted for EVAR with femoro-femoral crossover but continued groin leakage from a post-operative seroma necessitated wound exploration, lavage and sartorius flap. He recovered well and is completing a three-month course of antibiotics as an outpatient.
A 57-year-old female was admitted for a common femoral endarterectomy and femoro-femoral crossover. Post-operatively her wound dehisced leading to exposure of the underlying graft and she returned to theatre for washout, exploration and sartorius flap. She continues to recover on long-term antibiotics.
Conclusion: Graft coverage with a sartorius muscle flap, in combination with long-term antibiotics, remains a viable rescue management for patients with groin wound infection and dehiscence around prosthetic grafts.

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0627: EVALUATING A NEW INTRAOPERATIVE CLASSIFICATION SYSTEM FOR REPORTING COMPLEXITY LEVEL IN ENDOVENOUS PROCEDURES – THE ASPVCS CLASSIFICATION

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Objective: To construct new classification for reporting complexity in endovenous procedures -the Ashford & St Peter's Venous Classification System (ASPVCS).
Method - ASPVCS is constructed using four domains: number of truncal veins treated, number of zone avulsions, number of major anatomical variations (e.g. significant bending), and number of minor anatomical variation (e.g. need for side pressure). Total operative duration used as proxy for level of complexity. Effect of each domain on duration quantified using correlation and Regression analysis.
Result: - ASPVCS classification applied on 69 patients undergoing 82 procedures. Median age was 64. Number of main truncal veins treated was 1 (55%), 2 (25%), 3 (16%) and 4 (4%). Major anatomical variations found in 45% of cases. Average procedure duration was 44 min (13-155 min). Significant correlation found between operative duration and total number of main vein trunks (0.62. $p<.0001$) and number of major anatomical variations (0.36. $p < 0.05$). Multiple regression analysis showed all domains apart from minor anatomy variation do explain variance in operative duration ($R2 = .55$, $R2Adjusted = .52$, $p < .05$).
Conclusion - ASPVCS scoring can be used in reporting and predicating outcome for intraoperative anatomical variation and is correlated to level of procedure complexity.

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0823: DELAYS IN DELIVERY OF CAROTID SURGERY

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Introduction: Nice guidelines recommend that patients with high-risk transient ischaemic attack or non-disabling stroke should receive carotid endarterectomy within 7 days of referral to reduce the risk of stroke.
Method: A retrospective study of all symptomatic patients who underwent carotid endarterectomy was conducted between 1/1/12 and 30/12/14 to assess adherence to NICE guidelines regarding carotid endarterectomy referral times. Data was collected from electronic records and paper notes using a pro forma. Deprivation quintile ranking was calculated from the national deprivation data set.
Result: 196 patients were identified. Overall 53% were treated within 7 days of referral. Guideline adherence improved each year (2012=45.5%, 2013=50.7%, 2014=64.3%). Patients with amaurosis fugax or highest deprivation ranking had lower adherence (38% amaurosis fugax. 5th quintile 44%). The number of referrals and operations were lower at the weekends (<5%).
Discussion: There was a clear improvement from 2012 to 2015. However 35.7% are still treated outside 7 days. To increase guideline adherence: access needs to improve, especially for those with higher deprivation rankings or amaurosis fugax. Access could be improved by: referring and operating at weekends; prioritising symptomatic patients over asymptomatic patients; transferring patients between consultants; considering dedicated emergency slots on theatre lists.

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0851: CHALLENGES FACING TIMELY INTERVENTION FOR CAROTID DISEASE IN MODERN VASCULAR NETWORKS

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Introduction: Centralization in vascular surgery services promotes large hub sites serving a network of hospitals. This produces challenges for time-essential procedures e.g. carotid endarterectomy (CEA). NICE guidance recommends carotid imaging within 7 days and CEA within 14 days from cerebral event. We assessed the time to surgery for patients from each of our network sites against these recommendations.
Method: National Vascular Registry data was analysed for each of the four centres in our network, from January 2013 to September 2015.
Result: HUB site showed median time (IQR) from event to CEA of 10 (6-14) days. This compares to spoke site 1: 13 (9-22), site 2: 11 (9-22), site 3: 15 (7-55). Resulting in adherence to NICE guidance of 78%, 52%, 72%, and 48% respectively for each site. Site 3 underwent improved vascular services during this time, which changed the median time from 41 (78-67) to 12 (7-17) days.
Discussion: Overall 31% of patients in our network had surgery outside the NICE recommendation. There was considerable variation by site of referral. Spoke 3 which joined the network during the audit showed improvement in time to surgery demonstrating the need for spoke surgeons to be present at regional sites beyond the hub.

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0925: THE "WEEKEND EFFECT" IN VASCULAR SURGERY ADMISSIONS: MEDICAL FACT OR POLITICAL FICTION?

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Aim: To investigate patient outcomes in lower limb ischaemia (LLI) and assess whether a weekend admission has a negative impact on patient care.
Method: Data from LLI admissions over 15 months was collected retrospectively on demographics, complication and mortality rates. Statistical analysis was performed using SPSS.
Result: 158 patients were identified. 116 were admitted on a weekday (group A) and 42 during the weekend (group B). Male to female ratio was 2.3 (group A) and 1.6 (group B) ($p=0.35$), with a mean age of 70 (SD 15.1) and 70.6 (SD 15.4) years respectively ($p=0.86$). Co-morbidities in the two groups were not significantly different: diabetes mellitus ($p=0.78$), ischaemic heart disease ($p=0.65$), renal impairment ($p=0.21$), pulmonary disease ($p=0.79$) and smoking ($p=0.20$). Time to intervention (radiological or surgical) was calculated as a mean of 2.5 days (group A) and 3.8 (group B) ($p=0.18$). Mortality was 6.9% (group A) and 11.9% (group B) ($p=0.63$). Return to theatre for bleeding or re-occlusion was not significantly different in the two groups ($p=0.53$), nor was the amputation rate ($p=0.82$).
Conclusion: Despite a trend towards longer time to intervention and increased mortality at the weekend, no statistically significant difference in patient outcomes during the weekend was identified.

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0963: TEMPORAL ARTERY BIOPSY: IS IT WORTH IT?

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